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The role of advance directives in preventing compulsory placement and coercive measures in Switzerland: a need to review present practice

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Summary

In Switzerland, where individual self-determination and self-responsibility are strong values, coercive measures are still very present in the care of individuals with mental health conditions. In 2022, over 18,000 cases of compulsory care placements were recorded – one of the highest rates in Europe [1]. The Swiss Academy of Medical Sciences (SAMS) is reviewing its guidelines on coercion to better support practice. The present viewpoint aims to contribute to such efforts by focusing on the role of advance directives in preventing unwanted compulsory placement and coercive measures.

Advance directives support individuals to document treatment preferences in anticipation of future incapacity. There is, though, differentiation between psychiatric and non-psychiatric cases: while treatment refusals for somatic conditions are typically considered binding, the preferences expressed in psychiatric advance directives can be overridden following compulsory placement. This creates a double standard that undermines self-determination for individuals with mental health conditions.

The present article advocates for uniform legal standards that would grant psychiatric advance directives equal binding force. It explores the validity of common arguments against doing so, suggesting that objections often rely on inconsistent or ethically flawed reasoning. The piece lays out arguments in support of modifying policy on psychiatric advance directives, suggesting that comparably binding directives might enhance patient autonomy, reduce the harm of coercive interventions, promote goal-concordant care, strengthen oversight, and address discriminatory policy.

As the Swiss Academy of Medical Sciences revisits guidelines on coercive practices, it is a good moment to consider the potential value of binding psychiatric advance directives as tools to uphold patient autonomy and contribute to broader efforts to reduce the harm of coercive practices.

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Introduction

In Switzerland, where individual self-determination is a strong value, coercive measures are still very present, particularly in the care of individuals with mental health conditions. In 2022, Switzerland recorded 18,367 cases of compulsory care placements, corresponding to roughly two individuals per 1,000 residents, one of the highest rates in Europe [1]. Despite common Swiss guidelines, there is significant regional variation, with the proportion of involuntary hospitalisations among all psychiatric cases ranging from 10% to nearly 40%, depending on the canton [2]. Coercive practices, broadly defined as interventions imposed "against the patient's self-determined wishes or in spite of his/her opposition" [3], can include compulsory placement, involuntary treatment, seclusion, and restraint. Given the recognised harms of coercive practices, recent reports emphasise the need for change [4].

The current guidelines from the Swiss Academy of Medical Sciences already require justification of restrictions on self-determination; they establish that coercion should only be applied as a last resort according to the principle of proportionality [3]. The Swiss Academy of Medical Sciences is actively reviewing its guidelines on coercion – this presents an opportunity to freshly consider how to mitigate the harms [3]. The present viewpoint aims to contribute to such efforts by focusing on the role of advance directives in preventing compulsory placement and coercive measures. A joint crisis plan, a form of advance statement, is a key tool with proven efficacy in reducing the use of coercion [5].

Advance directives and coercive measures

Advance directives support self-determination in clinical settings by allowing individuals to predefine significant aspects of future medical care and express preferences with legal force. Today, nearly half of those over 65 in Switzerland have an advance directive [6]. According to the Swiss civil code (ZGB), competent individuals can use advance directives to specify which medical treatments they consent to or refuse in the event of future incapacity (Art. 370–373) [7].

There is a clear double standard, though, when it comes to upholding advance preferences [8]. Outside the context of compulsory care, advance directives can be used to refuse treatment in a binding way, even if such refusal might lead to self-harm, conflict with medical judgement, or place additional burdens on the healthcare team or family members (ZGB, Art. 370–373). This is not so in the case of compulsory care; following compulsory placement and loss

of decision-making capacity such that an advance directive is activated, advance preferences merely need to be "taken into account" (ZGB, Art. 433), and clinical best judgement can supersede treatment refusals. Of note, compulsory placement can occur with or without loss of decision-making capacity (ZGB, Art. 426).

This creates inconsistencies. Preferences expressed in an advance directive regarding non-psychiatric treatments remain binding, even if those preferences have been expressed by someone now under compulsory care. Moreover, preferences regarding psychiatric treatment remain binding if the person is voluntarily undergoing inpatient psychiatric treatment (ZGB, Art. 435). Following compulsory placement, though, advance directives can do very little to uphold someone's right to refuse unwanted psychiatric care if those preferences go against clinical best judgement. Psychiatry, thus, deviates from the standards applied to non-psychiatric care. Although this psychiatric exceptionalism has attracted critical scrutiny from legal scholars, ethicists, and healthcare professionals [8–11], it has not yet led to changes in policy.

Equal standards for all advance directives

Uniform standards for advance directives would allow individuals to draft advance directives while competent that would be binding in the event of possible compulsory placement. These directives could express treatment preferences or reject specific psychiatric interventions; refusals could not be overridden, even if they incur risk. By analogy with non-psychiatric care, the right to treatment refusal would extend to rejecting involuntary hospitalisation, just as one can refuse admission to a general hospital or intensive care unit. Possible harm to others, on the other hand, is a concern that can justify compulsory placement and needs to be considered in the policies on advance directives [12].

Standardising advance directive policy would help eliminate discrepancy in how those with and without mental health conditions are treated. The call for binding psychiatric advance directives is thus part of a broader case for equal rights – regardless of diagnosis or treatment setting – and the abolition of laws that specifically target individuals with mental health conditions [1]. There is significant evidence to support the value of psychiatric directives with binding legal force [13, 14].

A few key arguments emerge in the case for consistent advance directive policy across settings:

1. Strengthening patient rights and autonomy – Given the prevalence of coercive measures in Switzerland, consistent advance directives – binding even in the case of compulsory placement – may be an important tool to balance the power of institutions and clinicians.

2. Mitigating the harm of coercive interventions – To serve their function of increasing self-efficacy and agency, advance directives need more weight precisely in the settings where they can presently be overridden.

3. Facilitating the personalisation of medicine – Advance directives help align care with the person's stated goals and preferences, an important component of which is avoiding unwanted clinical interventions. This aim would be strengthened if valid refusals encompassed both psychiatric and non-psychiatric preferences.

4. Improving systems of oversight – Advance directives that stand even in the case of compulsory placement would draw attention to coercive practices and likely strengthen reporting and oversight mechanisms, limiting misuse and abuse.

5. Eliminating "special legal standards" – Advance directives with equal status help eliminate differential treatment of those with mental health conditions by targeting inconsistencies in standards for psychiatric and non-psychiatric care.

While there are strong arguments in favour of reducing differential treatment by modifying advance directive policy [8, 15], the idea of binding psychiatric advance directives has also raised concern and met resistance [16, 17]. We argue that many of the common arguments against binding psychiatric advance directives reflect flawed reasoning.

These arguments and their shortcomings are summarised below:

1. *"This is how psychiatry has always worked; coercion is, regrettably, part of psychiatric care."*

This reflects an "is-ought fallacy", where tradition is conflated with ethical justification. Just because something has been done does not validate continuing to do so. This is rather a call for the introduction of appropriate alternative interventions.

2. "Giving advance directives too much legal force in psychiatric cases may lead to preventable deaths."

In non-psychiatric care, people are allowed to make decisions through advance directives that could lead to their death, such as rejecting resuscitation. Concerns about legal liability or reputational damage are pragmatic, not ethical, arguments.

3. *"Psychiatric patients aren't typically at life's end, so advance directives don't apply."*

This reflects a flawed premise. Preferences expressed in advance directives are not solely relevant to end-of-life scenarios.

4. *"It is morally wrong not to try to save lives in psychiatry."*

This involves a slippery slope concern that allowing self-determination in psychiatry will lead to a more global devaluation or neglect of individuals with mental illnesses, as seen in Nazi-era euthanasia programmes. The concern is not inevitable nor contained in the premise of respecting treatment refusal.

5. *"We don't have the resources to honour advance directives in compulsory care."*

This reflects an ethically questionable trade-off, as resource constraints should not override patient autonomy. While pragmatic concerns about staffing and funding are valid, they require societal discussion and cannot be considered an immutable given.

6. *"Assessing capacity during a crisis to know whether or not an AD should go into effect is too difficult."*

While challenging, this cannot justify denying the right to self-determination. Instead, it is an argument for developing appropriate methods for capacity evaluation in such circumstances.

7. *"Coercion is justified because people are often grateful afterwards."*

This relies on a problematic normative premise that paternalism is acceptable. It conflicts with the right to self-determination. Restricting this argument to psychiatry discriminates against individuals with mental illnesses.

8. *"Binding psychiatric advance directives could be used defensively, more to protect institutions from liability than to benefit the patient."*

The concern that advance directives might shift responsibility for care decisions onto the patient applies to both psychiatric and non-psychiatric advance directives alike. This is not a reason to differentiate between advance directive types but rather a call to consider the responsibility of clinical beneficence more generally.

Conclusion

There are presently clear double standards when it comes to the role of advance directives in psychiatric and non-psychiatric care. Unless convincing reasons can be put forward, such disparities amount to discrimination against vulnerable patient groups. Eliminating such double standards will be an important step towards addressing concerns about present coercive practices in Switzerland.

The common arguments against standardising advance directives across settings are ethically uncompelling. There is clear ground to reconsider advance directive policy as part of a larger effort to revise coercive practices in Switzerland. In moving ahead, it will be necessary to determine how ethical concerns intersect with clinical consideration such that advance directives meaningfully contribute to high-quality, goal-concordant care, including psychiatric care.

The present viewpoint is based on a speech given by Prof. Biller-Andorno at the Award Ceremony of the Dr. Margrit Egnér Preis 2024 (cf. https://margritegner.ch/2024-preisverleihung/ *).*

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References

1. Socialdesign; Forschungsgruppe Mental Health Care and Service Research. Evaluation der Bestimmungen zur fürsorgerischen Unterbringung (FU; Art. 426 ff. ZGB) [Internet]. Bern: Bundesamt für Justiz; 2022 [cited 2025 Apr 18]. Available from: https://www.bj.admin.ch/bj/de/home/publiservice/publikationen/externe/2022-08-02.html
2. Morandi S, Silva B, Masson A. Nationale Zahlen zur fürsorgerischen Unterbringung in der Schweiz: Bestandesaufnahme und Perspektiven. Lausanne: Departement of Psychiatry, Lausanne University Hospital; 2021. Report commissioned by the Bundesamt für Gesundheit.
3. Swiss Academy of Medical Sciences. Coercive measures in medicine: Revision of guidelines [Internet]. Bern: Swiss Academy of Medical Sciences; 2025 [cited 2025 Apr 18]. Available from: https://www.samw.ch/en/Ethics/Topics-A-to-Z/Coercive-measures-in-medicine.html
4. Baggio S, Kaiser S, Huber CG, Wullschleger A. Effect of coercive measures on mental health status in adult psychiatric populations: a nationwide trial emulation. Epidemiol Psychiatr Sci. 2024 Sep;33:e35. http://dx.doi.org/10.1017/S2045796024000416.
5. de Jong MH, Kamperman AM, Oorschot M, Priebe S, Bramer W, van de Sande R, et al. Interventions to reduce compulsory psychiatric admissions: a systematic review and meta-analysis. JAMA Psychiatry. 2016 Jul;73(7):657–64. http://dx.doi.org/10.1001/jamapsychiatry.2016.0501.
6. Pro Senectute, editor. Selbstbestimmung bei Urteilsunfähigkeit – Zahlen und Fakten. Zürich: Pro Senectute Schweiz; 1 Oct 2017. Schweizerische Umfrage (Forschungsinstitut gfs-zürich), August 2017.
7. Switzerland. Schweizerisches Zivilgesetzbuch (ZGB), SR 210, Art. 370–373. Bern: Swiss Confederation; 1907 [cited 2025 June]. Available from: https://www.fedlex.admin.ch/eli/cc/24/233_245_233/de
8. Trachsel M, Biller-Andorno N. Mit zweierlei Mass: Die mangelnde Verbindlichkeit von Patientenverfügungen bei untergebrachten Personen mit psychischen Störungen in der Schweiz [Applying a double standard: the lacking binding character of advance directives of involuntary committed patients with mental disorders in Switzerland]. Ethik Med. 2016;28(3):239–47. http://dx.doi.org/10.1007/s00481-016-0407-7.
9. Bridler R. Das neue Erwachsenenschutzrecht und die Psychiatrie: Einen Schritt vor, zwei Schritte zurück. Schweiz Arzteztg. 2013;94(12):486–9. http://dx.doi.org/10.4414/saez.2013.01312.
10. Gassmann J, Bridler R. Fürsorgerische Unterbringung. In: Fountoulakis KN, Affolter-Fringeli A, Biderbost Y, Steck Y, editors. Fachhandbuch Kindes- und Erwachsenenschutzrecht. Zürich: Schulthess Juristische Medien AG; 2016. pp. 329–40.
11. Wüthrich U. Die Patientenverfügung in der schweizerischen Psychiatrie. GesR. 2023;4:205–11.
12. Gloeckler S, Scholten M, Weller P, Keene AR, Pathare S, Pillutla R, et al. An International Comparison of Psychiatric Advance Directive Policy: across eleven jurisdictions and alongside advance directive policy. Int J Law Psychiatry. 2025;101:102098. http://dx.doi.org/10.1016/j.ijlp.2025.102098.
13. Braun E, Gaillard AS, Vollmann J, Gather J, Scholten M. Mental health service users' perspectives on psychiatric advance directives: A systematic review. Psychiatr Serv. 2023 Apr;74(4):381–92. http://dx.doi.org/10.1176/appi.ps.202200003.
14. Scholten M, Efkemann SA, Faissner M, Finke M, Gather J, Gergel T, et al. Opportunities and challenges of self-binding directives: A comparison of empirical research with stakeholders in three European countries. Eur Psychiatry. 2023 Jun;66(1):e48. http://dx.doi.org/10.1192/j.eurpsy.2023.2421.
15. Hotzy F, Cattapan K, Orosz A, Dietrich B, Steinegger B, Jaeger M, et al. Psychiatric advance directives in Switzerland: knowledge and attitudes in patients compared to professionals and usage in clinical practice. Int J Law Psychiatry. 2020;68:101514. http://dx.doi.org/10.1016/j.ijlp.2019.101514.
16. Hotzy F, Jaeger M. Clinical relevance of advance directives in adult psychiatry: A systematic review. Eur Psychiatry. 2016;33:85–91. http://dx.doi.org/10.1016/j.eurpsy.2015.12.008.
17. Layat C, Huber C. Patientenverfügungen im psychiatrischen Kontext: Herausforderungen und ethische Spannungsfelder. Ethik Med. 2019;31:245–55. http://dx.doi.org/10.1007/s00481-019-00522-w.